Patient Record Audit: Section 3 CPD requirements

Process for use of Patient Record Audit tools

The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Background

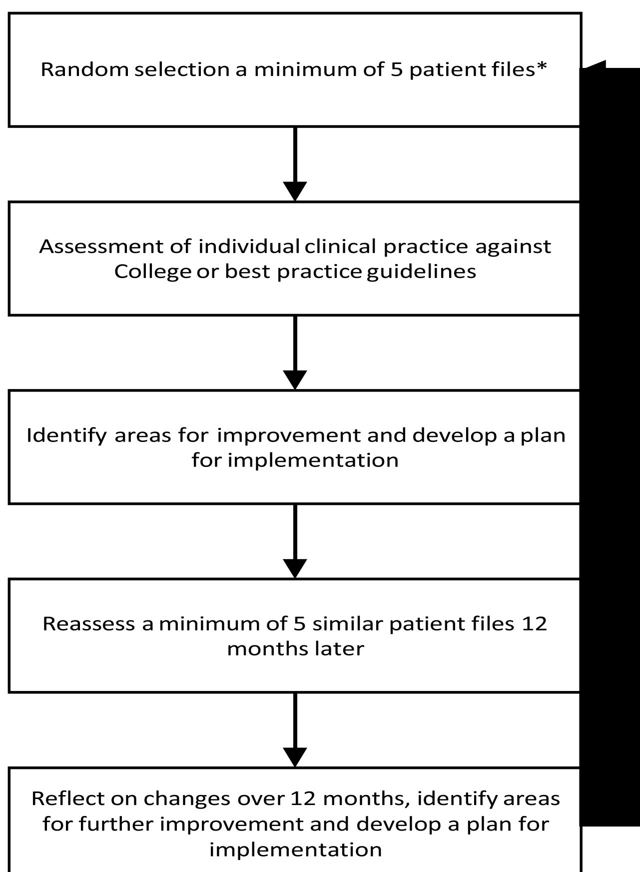
Patient record audit tools have been developed from the RANZCP suite of clinical practice guidelines and physical health consensus statement, and have been approved for Section 3, Category 1 (Practice Development and Review) of the College's CPD program.

Completion of these patient record audits require the review of a sample of clinical files that are used by the audit participant. A patient record audit should be inclusive of a minimum of 5 randomly selected patient files to ensure that the outcomes can be measured against College or best practice guidance to determine any areas for improvement in current clinical practice. The audit quality can be enhanced by requesting a peer to randomly select the files to ensure that the audit sample is not skewed.

A minimum of 5 patient records are recommended to be audited. A separate audit tool should be used for each patient record audited to provide an overview of current practice, to identify areas for improvement and to develop a plan for practice improvement.

The audit process is outlined in figure 1 below.

Figure 1: Flowchart of patient record audit process



*recommended that the patient files are randomly selected by a peer, if available, to ensure that the sample is not skewed

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